PROPOSAL FOR A SECTION 1915(b)(4) Initial Selective Contracting Waiver Program

Waiver Application Form

This streamlined waiver application form, adapted from the Section (b)(1) waiver application by the Dallas Regional Office, is for a State's use in requesting implementation of an initial Section 1915(b)(4) Selective Contracting waiver program.

The State may wish to use this standardized application form to streamline the waiver process and, thus, eliminate unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request a waiver and CMS's effort to approve the waiver proposal. Where possible, the proposal is in the form of a check-off document. However, the applicant will be required to provide detailed explanations on appendices.

All waiver requests under Section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on recipient access to services, quality of care and its projected impact (42 CFR 431.55(b)(2)). This model Section 1915(b)(4) waiver application form will help States provide sufficient documentation for the Secretary to be able to determine whether the statutory and regulatory requirements of Section 1915(b) of the Act have been satisfied.

The CMS Regional Office will be glad to meet with the State, set up a conference call, or assist the State in any way to complete the application.

INTRODUCTION

On Appendix I, please provide a short narrative description, in one page or less, of your program, the background to your program, the objective of your program, and any other information relating to your request for a Medicaid waiver.

See Attached Appendix I for Introduction.

II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

A. The State of **Oklahoma** requests a waiver under the authority of Section 1915(b)(4) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

B. Desired Effective Dates: This waiver is requested for a period of 2 years; effective **1-1-2003** and ending **12-31-2005**.

C. The waiver program is called **Oklahoma Medicaid Non-Emergency Transportation(SoonerRide) Waiver.**

D. Geographical Areas of the Waiver Program:

The waiver will be implemented in the following areas of the State:

(1) _____X_____Statewide

(2) _____ Other-than-Statewide (Cities and Counties are Listed on Appendix II.D.(2))

(Note: if the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification must be submitted to CMS-.)

E. State Contact: The State contact person for this waiver is **Connie Wildman** and can be reached by telephone at **(405)522-7324**.

F. Statutory Authority: The State's waiver program is authorized under ***Section 1915(b)(4) of the Act*** under which the State restricts the provider from or through whom a recipient can obtain medical care. Please

indicate the State's reason for selectively contracting and the need for the 1915(b)(4) authority.

Oklahoma Medicaid recipients will be restricted to the broker serving his/her area, for non-emergency transportation services.

G. *Relying upon the authority of the above section, the State would also like a waiver of the following Sections of the Act:*

1. __ ***Section 1902(a)(1)*** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. (See Appendix II. D.(2))

2. __ ***Section 1902(a)(10)(B)*** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as _____that will not be available to other Medicaid recipients not enrolled in the waiver program.

3. X ***Section 1902(a)(23)*** - Freedom of Choice-

-section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals in this waiver are constrained to receive waiver services from selected providers.

4. X ***Other Statutes Waived*** - In Appendix II.G.4, please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

See Appendix II.G.4

H. Recipient Figures: Please indicate the expected number of Medicaid recipients that will be covered by this waiver:

250,000

I. Waiver Populations: The waiver is limited to the following target groups of recipients. Check all items that apply:

1. X Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. X Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3. X Blind/Disabled Children and Related Populations (SSI)

4. X Blind/Disabled Adults and Related Populations (SSI)

5. X Aged and Related Populations

6. X Foster Care Children

7. X Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children=s Health Insurance Program through Medicaid

8. __ Other Population(s) Included - If checked, please describe these populations below.

9. __ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)
   - i. ___ Children with special needs due to physical and/ or mental illnesses,
   - ii. ___ Older adults,
   - iii. ___ Foster care children,
   - iv. ___ Homeless individuals,
   - v. ___ Individuals with serious and persistent mental illness and/or substance abuse,
   - vi. ___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
   - vii. __ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
   - viii. __ Other (please list):

J. Excluded Populations: The following recipients are excluded from participation in the waiver:

1.__ have Medicare coverage, except for purposes of Medicaid-only services;

2.__ have medical insurance other than Medicaid;

3.__ are residing in a nursing facility;

4.___ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5.__ are enrolled in another Medicaid managed care program;

6.__ have an eligibility period that is less than 3 months;

7.__ are in a poverty level eligibility category for pregnant women;

8.__ are American Indian or Alaskan Native;

9.__ participate in a home and community-based waiver;

10.__ receive services through the State=s Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12.__ are included under the State=s definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

- i.___ Children with special needs due to physical and/ or mental illnesses,
- ii.___ Older adults,
- iii.___ Foster care children,
- iv.___ Homeless individuals,
- v.___ Individuals with serious and persistent mental illness and/or substance abuse,
- vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability,
- vii.__ Non-elderly adults with rare or life-threatening conditions; e.g., HIV, cancer, or
- viii.__ Other (please list):

13._X_ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons on Appendix II.J.9.

See Attached Appendix II.J.9.

K. Distance/Travel Times: On Appendix II. K., please define your access standards for distance/travel times for recipients to receive services. Please explain how these travel standards differ from the without waiver travel standards.

See Attached Appendix II.K

L. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on recipient access to care of adequate quality. **This assessment is to be submitted to CMS 3 months prior to the end of the waiver period**. Entities that may perform the assessment include universities, actuaries, etc. Examples of independent assessments are available upon request.

M. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C; 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

III. PROGRAM IMPACT:

In this section, please provide information on (1) affected recipients, (2) services, and (3) waiver providers.

A. Affected Recipients

1. Notification Process: On Appendix III. A. 1, please explain in detail the process through which recipients will be notified of the waiver program provisions.

See Attached Appendix III.A.1

Recipient's Choice of Providers. If more than one provider is selected per geographical area, please address the following points on Appendix III. A. 2:

N/A

(a) Will recipients be given the choice of selected providers? If so, how will they

select a provider, and how will the provider be informed of the recipient's choice?

(b) How will beneficiaries be counseled in their choice of waiver providers?

(c) How will the recipient notify the State of provider choice?

(d) Define the time frames for recipients to choose a waiver provider.

(e) Will the recipients be auto-assigned to a waiver provider if they do not choose? Yes ____ No ____

(i) If so, how many days will they have to choose?

(ii) Describe the auto-assignment process and/or algorithm.

3. Implementation Process

(a) Will implementation occur all at once?

__X__ Yes

____ No. Please describe on Appendix III. A.3.(a) the time frames for implementation, including time frames for inclusion of current Medicaid recipients.

(b) Will there be accommodations for special-needs populations such as the disabled, etc.?

__X__ Yes. Please explain on Appendix III. A.3.(b). States may wish to refer to the October 1998 CMS document entitled ''Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs'' as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form. .

See Attached Appendix III.A.3. (b)

____ No

4. Education Materials: Please provide all relevant recipient education materials, including the **initial notification letter** from the State. Also, check the items which will be provided to the recipients:

a. _X_ a **brochure** explaining the program

b. ___ if more than one provider is selected per geographical area, a **form** for selection of a provider

c. ___ if more than one provider is selected per geographical area, a **list of qualified providers** serving the recipient's geographical area;

d. ___ a ***new*** **Medicaid card** which includes the provider's name and telephone number or a ***sticker*** noting the provider's name and telephone number to be attached to the original Medicaid card (please specify which method);

e. _X_ **a brief presentation and informing materials** to each new recipient describing how to appropriately access services under the waiver program, including the appropriate usage of emergency rooms and family planning services, and how to exercise due process rights; and

f. _X_ other items (please explain on Appendix III. A. 4.f.):

See Attached Appendix III. A.4.f.

5. Languages. Describe how the State has made a concerted effort to determine if and where significant numbers of non-English speaking recipients reside, and has subsequently made the program educational materials available in the native languages of those groups.

The State of Oklahoma currently accommodates for English and Spanish speaking recipients by having personnel and educational materials available in the local Department of Human Services county offices and the SoonerCare enrollment broker. The Non-Emergency Transportation Broker also has these same accommodations.

B. Services:

1. Description of Services:

Please identify the Medicaid services that <u>will</u> be affected by the selective contracting process:

<u>Non-Emergency Transportation Service</u>

_____
_____
_____
_____
_____

If additional space is needed, please create an Appendix III. B. 1.

2. Emergency and Family Planning: In accordance with regulations, freedom of choice of provider in cases of <u>emergency</u> and <u>family planning</u> services will not be restricted.

C. Selection and Availability of Providers

1. Selection Criteria: On Appendix III.C.1, please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Included are the approximate weights associated with each of the criteria.

See Attached Appendix III.C.1

2. Numbers and Types of Qualifying Providers: For each of the services covered by the selective contracting waiver, please list on the chart below the numbers of Medicaid providers available per geographical area to provide services to the waiver population. The chart also compares the number of providers expected under the waiver with what existed prior to the waiver.

Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) - for facility programs, or vehicles (by type, per contractor) - for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

For non-institutional services provided by an ''entity'' (i.e. versus an independent practitioner), please provide information on Appendix III. C.2. as to the numbers of actual care givers per entity that will be available to provide the waiver service(s).

SERVICE:

Provider Types	***Number of Medicaid Providers Participating Before the Waiver***	***Number of Medicaid Providers <u>Expected</u> to Participate Under the Waiver***
1. Metropolitan Tulsa Transit Authority	1 Broker 25 subcontractors	1 Broker 25 subcontractors
2.		
3.		
4.		

3. Program Requirements. Below is a description of provider qualifications and requirements under the waiver. Providers **<u>must</u>**:

a. be Medicaid qualified providers and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of service and meet general qualifications for enrollment as a Medicaid provider;

b. not refuse to provide services to a waiver participant or otherwise discriminate against a participant solely on the basis of age, sex, race, religion/creed, sexual orientation, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type; and

c. ____other qualifications (explain on Appendix III. C.3.c):

4. Provider/ Beneficiary Ratio: Please calculate and list below the expected average provider/beneficiary ratio for each geographical area or county of the

program, and then provide a statewide average and how it differs from the regular Medicaid program.

Area (City/County/Region)	***Provider-to-Beneficiary Ratio***	
	Without the Waiver	***Under the Waiver***
State Wide	***1 Broker 25 subcontractors***	***1Broker 25 subcontractors***

Statewide Average: (e.g., 1:500, 1:1000)

5. Change of Provider: Please answer the following questions regarding beneficiary changes of providers and/or actual care givers:

a. *Change of Providers:*

If there is more than one selected provider per geographical area, can the beneficiaries change providers?

_____ No. Please explain on Appendix III.C.5.a.

_____ Yes. Please describe on Appendix III.C.5.a. the process, reasons, etc.

N/A

b. *Change in Actual Care Givers:*

(I) For non-institutional waiver services provided by an ‘‘entity,’’ can the beneficiaries change their individual care givers within the selected provider?

____ No. Please explain on Appendix III.C.5.b.

____ Yes. Please describe on Appendix III. C.5.b. the process, reasons, frequency, etc.

N/A

d. Enrollment/Disenrollment: Please describe the State's enrollment process for PHPs by checking the applicable items below:

1. **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2. **Administration of Enrollment Process**:

(a) X State staff conduct the enrollment process.

(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section II.F. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _____

ii. Procurement method:

(A). ____Competitive

(B). ____Sole source

iii. Please list the functions that the contractor will perform:

(c)__ State allows PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)__ Mandatory for populations in Section II.I

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c) X Other (please describe):

Oklahoma Medicaid recipients, with the exception of excluded populations, are automatically enrolled in the Non-Emergency Transportation Program.

4. **Enrollment: N/A**

(a)__ The State will make counseling regarding their PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate PHPs and providers based on their medical needs. Please describe.

(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:
i. ___ mail
ii.___ phone
iii.___ in person at ____
iv.___ other (please describe):

(d)__ [Required] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)__ If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to a PHP that includes their current provider or to a PHP that is capable of serving their particular needs?

(h) __ The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in a PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment: N/A**

(a)__ The State allows enrollees to disenroll/transfer between PHPs. Please explain the procedures for disenrollment/transfer:

(b)__ The State does not allow enrollees to disenroll from the PHP.

(c)__ The State monitors and tracks disenrollments and transfers between PHPs. Please describe the tracking and analysis:

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i ___ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP

ii.___ PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e)__ The State does not have a lock-in, and enrollees in PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. Provider's Change of Beneficiary: Please answer the following questions regarding provider changes of beneficiaries:

N/A

a. If more than one provider is selected per geographical area, can providers request to reassign a beneficiary from their care?

No _____

Yes ____

If yes, **it is important that reasons for reassignment are not discriminatory in any way - including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnosis - against the enrollee**. In cases of beneficiary change, the beneficiary should agree upon the reassignment as well. Please describe the reasons for which the provider can request reassignment of an enrollee:

b. The State reviews and approves all provider/PHP-initiated requests for enrollee transfers or disenrollments.

c. ***If the reassignment is approved,*** the State must notify the beneficiary in a direct and timely manner of the provider's/PHP's desire to remove the beneficiary from the provider's caseload/PHP's membership.

d. The provider/PHP must keep the participant as a client until another provider/PHP is chosen or assigned. Please specify on Appendix III. C. *6.b.* if the State's policy differs in any way from those listed above.

7. Reimbursement of Providers: The State should explain how it pays providers under the waiver program. Include whether providers are pre-paid, how often paid, and what is the basis of payment (if payment is made per ride, beneficiary, or service rendered.

IV. ACCESS TO CARE AND QUALITY OF SERVICES:

A. General: A 1915(b)(4) waiver program must, at a minimum, not adversely affect the beneficiary's access to quality medical services. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency services and family planning services must not be restricted.

B. Grievance Process: On Appendix IV. B., please describe the process that will be in place to handle complaints and grievances under the waiver program. Please discuss how this will compare to the regular Medicaid program. ***NOTE: Beneficiaries must have available and***

be informed of a formal appeals process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing. Please fully describe on Appendix IV. B.

See Attached Appendix IV.B.

C. Monitoring Access:

1. Service Access Areas: On Appendix IV. C. 1, please explain in detail the State's plans to monitor and improve the following areas of service access:

See Attached Appendix IV.C.1

a. time and distance

b. waiting times to obtain services

c. provider-to-beneficiary ratios

d. beneficiary knowledge of how to appropriately access waiver services

e. access to emergency services

2. Procedure for Monitoring: *Beneficiary access to care will be monitored during the waiver period by the State as indicated below. Records will be maintained to identify lack of access trends and for reporting purposes. Check which monitoring activities will be in effect to assure that beneficiary access to care is not substantially impaired. Also, on Appendix IV. C. 2, identify the means the State will employ to intervene to correct problems. If any of the following differ from the State's program, please indicate and explain on Appendix IV. C. 2:*

a. **An advisory committee** will be designated during the phase-in period to address beneficiary and provider concerns.

X B **A Hotline** with a toll-free number will be maintained which handles any type of inquiry, complaint, or problem.

X C. **Periodic comparison** of the numbers of providers available to the Medicaid recipients before and under the waiver will be conducted. The intent of this review is to identify whether the waiver may have reduced access to specific types of

providers. Also, for non-institutional services, a periodic comparison will be made of the individual care givers within an ‘‘entity’’, where applicable, in order to ensure that the same level of access is maintained throughout the waiver period.

The Broker will continue to be reviewed to assure adequate number of transportation service providers are maintained to provide transportation to all recipients residing in all seventy-seven (77) counties of the state of Oklahoma and that the level of access remains consistent throughout the waiver.

d. **Periodic beneficiary surveys** (which will contain questions concerning the beneficiaries' access to all services covered under the waiver) will be mailed to a sample of waiver recipients.
e. **Other** (explain on Appendix IV. C. 2. e.)

D. Monitoring Quality of Services: On Appendix IV. D, please explain in detail the State’s plans to monitor and assure quality of services under the waiver program. Please describe how will the State monitor the following:

1. **Beneficiaries' reasons for changing providers** in order to detect quality of care problems (not only actual changes, but also requests to change specific individual care givers and/or providers);

N/A

2. **Hotline**;

N/A

3. **Periodic beneficiary surveys** (which question the quality of services received under the waiver) are mailed to a sample of waiver recipients;

N/A

4. **Complaints**, grievance and appeals system;

See Attached Appendix IV.D

5. **Other** (explain on Appendix IV.D.5.).

E. Other Quality Monitoring:

1. **Quality of Services** will be further monitored through the mechanisms outlined in Appendix IV. E. 1. Quality of services problems identified will result in a desk review or an onsite medical review to resolve the problems.

   See Attached Appendix IV.E.1

2. **Periodic reviews**: On Appendix IV. E. 2, please describe what areas will be covered in the State's periodic reviews of claims files and medical audits, including the types of care reviewed and how the problems will be resolved. Please include how often these reviews will take place.

   See Attached Appendix IV.E.2

3. **State Intervention:** If a problem is identified regarding access to care and quality of services problems, the State *will intervene* as noted below (please indicate which of the following the State utilizes:

   (a) __X__ Education and informal mailing

   (b) ___X_____ Telephone and/or mail inquiries and follow-up

   (c) ___X_____ Request that the provider respond to identified problems

   (d) ___X____ Referral to program staff for further investigation

   (e) __X__ Warning letters

   (f) ___X____ Referral to State's medical staff for investigation

   (g) __X__Corrective action plans and follow-up

   (h) _____ Change beneficiary's provider

   (i) _____ Restriction on types of beneficiaries

   (j) _____ Further limits of the number of assignments

   (k) _____ Ban on new assignment of beneficiaries

(l) _____Transfer of some or all assignments to a different provider

(m)_____ Suspension or termination as a waiver provider

(n) __X_Other (explain on Appendix IV. E.3.n).

See Attached Appendix IV.E.3.n

V. COST EFFECTIVENESS:

A. General: In order to demonstrate cost effectiveness, a waiver request must show that the cost of the wavier program will not exceed what Medicaid's cost would have been in the absence of the waiver. The cost-effectiveness section provides a methodology to demonstrate that the waiver program will be less costly than what costs would be without the waiver.

The State should use its Medicaid fee-for-service experience to develop the cost-effectiveness section of the waiver program. When submitting an initial 1915(b)(4) waiver, the State should estimate the cost of providing the waiver services under the waiver and provide a comparison to the projected cost without the wavier. The costs under the waiver may be estimated based on responses to a request for proposals (RFP) from the potential contractors. The amount of the savings may be estimated based on the discount from the State Plan rates represented by the RFP bids. To project the net saving, the State should add any additional costs associated with administering the waiver. This amount should be compared to the costs of delivering the services without the waiver. All cost comparisons should be made separately for each year of the waiver.

B. Rationale for Expected Cost Savings: On Appendix V. B., please explain the State's rationale for expected cost reductions under the waiver program. Include all assumptions made regarding changes due to inflation, utilization rates, State Plan payments rates, and other factors.

See attached Appendix V.B.

C. Format for Showing Savings Summary
(Include supporting documentation, i.e., charts spreadsheets, in Appendices V.C.)

1. The following schedule shows the calculation of the State's program benefit costs under the waiver (if these are not applicable to the State's methodology, please attach the calculations).

Cost Saving Category	*Costs Expected Without the Waiver*	*Projected Percentage of Cost Savings*	*Total Benefit Savings*
1/1/03-12/31/03	*$10,097,009*	*4.6%*	*$430,026*
1/1/04-12/31/04	*$11,543,910*	*14.6%*	*$1,467,594*
TOTAL	*$21,640,919*	*9.8%*	*$2,247,620*

2. Costs Under the Waiver

a. Total waiver costs are expected to be **$19,393,299** during the 2-year waiver period. This includes **$19,043,299** in program benefit costs and **$350,000** in additional costs (management fees, administrative costs, bonus payments if any, etc.) which would not have been incurred had the waiver not been implemented. Also, please separate these cost out for each year of the waiver.

3. ***Additional Waiver Costs***

The following additional costs are expected to occur under the waiver:

a. Total additional administrative costs under the waiver, which would not be incurred if the waiver was not implemented, are expected to be **$350,000**.

b. Additional administrative costs are broken down as follows and a brief explanation of each cost item is included on Appendix V. C. 3.(b):

(1) ___ Contract Administration $_____

(2) ___ Systems Modification $100,000

(3) ___ Beneficiary Education, Outreach conducted by State employees. $_____

(4) ___ Beneficiary Education, Outreach conducted by contracted entity; $_____

(5) ___ Handling Complaints, Grievances and Appeals. $_____

(6) ___ Utilization Review System $ 50,000

(7) ___ Additional Staff $_____

(8) ___ Hotline Operation $_____

(9) ___ Quality Assurance Review System $ 50,000

(10) ___ Outreach, Education and Enrollment of Waiver Providers $_____

(11) ___ Other (start-up) $150,000

4. Costs Without the Waiver

The State projected what the costs would be without the waiver by first calculating the costs during the fiscal year prior to the waiver period. These base year cost data were then projected forward, adjusting for changes in utilization, characterization of affected beneficiaries, changes in payment rates or methodologies and changes in other State policies, to determine what costs would be without the waiver in effect during the proposed 2-year waiver period. The documentation to demonstrate what costs would be in the absence of the waiver is presented in **Exhibit 1**.

5. Program Savings

The schedule below shows how savings were calculated under the waiver:

Year	Cost Reductions Expected Under the Waiver	Minus: Total Additional Waiver Costs	Program Savings
2003	**$ 780,026**	**$350,000**	**$430,026**
2004	**$1,467,594**		**$1,467,594**
Total	**$2,247,620**	**$350,000**	**$1,897,620**

EXHIBIT #1

Costs Without the Waiver (Refer to number V.C.4. above):

	Eligibles ***(1)***	***Total Eligible Months*** ***(2)***	***NET Cap*** ***(3)***	***IBNR*** ***(4)***	***Subsistence*** ***(5)***	***Total Costs*** ***(6)***
TANF						
SSI						
OTHER						
TOTAL	***Not Available***	**3,050,098**	**$ 7,822,440**	**$301,921**	**$169,381**	***$8,293,742***

Base Year:

	Total Costs Projected of NET Service ***(7)***	***Utilization Factor*** ***(8)***	***Pricing Factors*** ***(11)***	***Third Party Liability Factors*** ***(12)***	***Other Policy Factors Affecting NET Services*** ***(13)***	***Total Costs of NET Services*** ***(14)***
TANF						
SSI						
OTHER						
TOTAL	***$8,293,742***	**1.165**	**1.045**	**1.0**	**1.0**	**$10,097,009**

Exhibit 2

Costs Without Waiver	**1/1/03 to 12/31/03**	**1/1/04 to 12/31/04**	**Total**
Statewide NET	**$10,097,009**	**$11,543,910**	**$21,640,919**
Costs Under the Waiver			
Statewide NET	**$9,316,982**	**$10,076,317**	**19,393,299**
Program Savings	**$780,026**	**$1,467,594**	**$2,247,620**
Administration Costs			
System Modification	(100,000)		(100,000)
Utilization Review	(50,000)		(50,000)
Quality Assurance	(50,000)		(50,000)
Other (start-up)	(150,000)		(150,000)
Waiver Savings	**$430,026**	**$1,467,594**	**$1,897,620**
Projected Percentage of Cost Savings	4.6%	14.6%	9.8%
PMPM Cost Under the Waiver	**2.92**	**3.08**	

Exhibit 3

Transportation Eligibles - Projection

	Waiver Yr 1 Total Member Months	Waiver Yr 2 Total Member Months
Jan	258,451	273,026
Feb	259,743	273,026
Mar	261,042	273,026
Apr	262,347	273,026
May	263,659	273,026
Jun	264,977	273,026
Jul	266,302	273,026
Aug	267,633	273,026
Sep	268,971	273,026
Oct	270,316	273,026
Nov	271,668	273,026
Dec	273,026	273,026
Total	**3,188,134**	**3,276,314**

Column Explanations for Exhibit 1

1. The MMIS indicated that this was the total number of TANF and SSI eligible by age and sex in the previous year.

2. The total eligible months was derived from the State's Medicaid Management Information System (MMIS) for the previous fiscal year (2002) to the waiver period.

3., 4., 5.
The MMIS disclosed that the costs in Exhibit 1 were incurred by the State during the base-year period for providing all medical service categories to the total person eligible months noted in column (2).

6. This is the cost for all State plan major services to be covered under the waiver program, based on actual incurred costs for the base year.

7. Base year total costs were obtained from column (6).

8. New policies adopted by the State after the base year affected utilization rates as follows:

   a. __ Inpatient rates will decrease as a result of the implementation of a DRG-based prospective payment system and lower average lengths of stay.

   b.__ Outpatient hospital utilization will increase due to an expanded ambulatory surgery program.

   c.__ Other service utilization will increase due to increased primary care services; and,

   d.__ Other utilization will increase/decrease.

11. FFS price adjustments implemented by the State since the base-year period resulted in the following:

   a.__ Inpatient hospital service costs are expected to increase due to an increase in room and board rates.

   b.__ Outpatient hospital service cost are expected to increase based on the annual CPI adjusted inflation factor.

   c.__ All other service costs are expected to increase due to fee-schedule increases for primary care service.

   d.__ Other service costs are expected to increase/decrease.

12. During the base-year period, the State did not exclude TPL recoveries for FFS inpatient hospital service costs. Since the total amount of TPL recoveries was $, this represented ___ percent ($_____ recoveries divided by $_____ total inpatient costs) of total inpatient costs. Therefore, ___ percent is posted under column 12 for inpatient services and is a negative adjustment.

13. Other policy factors that affected the base-year period costs were as follows:

    a.__ An increase in inpatient service costs will occur due to the implementation of a pre-admission review program for non-emergency inpatient admissions.

    b.__ A decrease in outpatient service is expected to occur due to the elimination of physical therapy coverage.

    c.__ A decrease in all other services is expected due to State elimination of TANF subsidy for public transportation fares; and

    d.__ An increase in clinic service costs was effective April 1, 1990, when section 6404 of the Omnibus Budget Reconciliation Act of 1989 and section 4704 of the Omnibus Budget Reconciliation Act of 1990 were implemented. This established a new clinic service for Federally Qualified Health Centers (FQHC). Reimbursement of FQHCs was increased to 100 percent of the reasonable costs of providing services to Medicaid beneficiaries. Community health centers and certain other Medicaid clinic providers were redesigned as FQHCs.

    e.__ Additional increases/decreases should occur.

14. Total projected costs are determined by multiplying the base-year period costs (column 7) by the percentage-adjustment factors in columns 8, 11, 12, and 13.

VI. REQUIREMENTS RELATING TO WAIVER UNDER SECTION 1915(b)(4) OF THE ACT

1. The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons.

a. X Although the organization of the service delivery and the payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more vigorous than those in the State plan.

b. X Providers must provide the full range of Medicaid services to be provided under the waiver.

c. X Providers must agree to accept as payment the reimbursement rate set by the State.

d. X Recipients residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority.

e. X There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the services.

2. APPENDIX D. describes the differences in the standards that providers must meet regarding reimbursement, utilization and quality under the waiver from those in the State plan. We also discuss how the different standards are consistent with access, quality, and efficient and economic provision of services.

See Attached Appendix D.

Appendix I

I. INTRODUCTION

The previous Non-Emergency Transportation (NET) System in Oklahoma was provided to recipients on a fee-for-service basis. Recipients would access transportation by means of their own vehicle, relatives or friends and volunteer transportation providers. The Medicaid recipient would receive reimbursement through filing a mileage claim at the local county Department of Human Service offices. This process became inefficient due to high incidents of fraud and abuse, client accessibility to services were still a problem due to transportation resources were not available in some Oklahoma counties.

The old system has been replaced with a new system called "SoonerRide" it is a capitated broker system for non-emergency transportation to Medicaid covered services. The Oklahoma Health Care Authority attained a broker that is another government entity to arrange for all non-emergency transportation for medical services. The program was implemented in June 1999 as a seven county pilot program. The program became statewide in May 2000.

The operation of the SoonerRide program resulted in: 1) reduced incidents of fraud and abuse; 2) increased client safety due to the creation and enforcement of uniform provider qualifications and standards; and, 3) higher level of compliance with federal mandate to provide medically necessary transportation to Medicaid recipients.

The waiver would allow the State to selectively contract with a broker. The broker is the gatekeeper and coordinator for non-emergency transportation needs for the recipients statewide. Medicaid recipients are automatically enrolled for coverage. The broker is paid a monthly capitated rate for qualified Medicaid eligible recipients.

Appendix II.G.4

The State of Oklahoma is requesting approval from CMS to waive the choice provision through section 1902 (a) (4) of the Act. This will enable the State to contract with ! broker. The broker will be authorized to provide services through a para-transit system developed to include demand response transportation service, bus services, shared ride taxis, non-profit and for profit provider for hire and individual volunteers. Additionally, when the broker determines necessity, private "volunteers may be utilized to provide NET services

EXCLUDED POPULATIONS

(1) Qualified Medicare Beneficiaries (QMB)

(2) Special Low Income Beneficiaries (SLMB)

(3) Qualifying Individuals I and II

(4) Medicaid recipients in a fully capitiated Health Maintenance Organization (HMO)

Appendix II.K

DISTANCE AND TRAVEL TIMES

A. State's Access Standards

1. Arrival on time for scheduled pick-up shall be standard practice. The broker is not required to wait more than fifteen (15) minutes after the scheduled pick up time.

2. Medicaid recipients will be timely transported to and from scheduled appointments. Medicaid recipients will be advised of the pick-up time for transportation to appointments after the transportation request has been assigned to the transportation provider.

3. In multiple-passenger situations, no Medicaid recipient will remain in the vehicle more than one hour longer than the average travel time for direct transport from point of pick-up to destination.

4. Late arrival or delivery must be reported to the dispatcher/transportation provider for the purpose of documenting the reason and appropriate follow-up.

5. If a delay of fifteen minutes or more occurs in the course of picking up scheduled riders, the dispatcher/provider must contact proposed riders at their pick up points to inform them of the delay in arrival of vehicle and related schedule. The transportation provider must advise scheduled riders of alternate pick up arrangements when appropriate.

6. Transportation, outside the area customarily used for health care services by the recipient's, is to be provided only when sufficient medical resources are not available in the area, or a health care provider has referred the recipient to health care services outside of the immediate community.

B. Appointment Waiting Time Standards

The Medicaid eligible recipient is required to schedule an appointment for medically necessary, non-emergency transportation needs 72 hours in advance. It is the responsibility of the Broker to make every effort to arrange for non-emergency transportation services with less than 72 hours notice and in instances when transportation is needed for urgent care services.

The recipient will be provided training by the local Department of Human Services Office and by the Broker on how to schedule transportation services, instead of expecting transportation on demand.

C. Travel Standards Prior to Waiver

The previous Non-Emergency Transportation (NET) System in Oklahoma was provided to recipients on a fee-for-service basis. Recipients would access transportation by means of their own vehicle, relatives or friends and volunteer transportation providers.

NOTIFICATION PROCESS

Oklahoma Medicaid recipients who are eligible to participate in the transportation waiver program are notified through the following means:

The recipient is verbally told and given written document (brochure) by the Department of Human Services caseworker about the non-emergency program at the time they apply and subsequently are certified in the Medicaid qualifying program. The brochure gives the recipient the process to access services, and a toll-free telephone number to use if he/she to request Non-Emergency Transportation (NET) services or has questions regarding the NET waiver services.

ACCOMMODATIONS FOR SPECIAL-NEEDS POPULATIONS

Before the Broker can begin operation of a Non-Emergency Transportation service, the Broker must meet and adhere to the requirements set forth in the Americans with Disabilities Act Requirement for Transportation Accessibility and Title XIX Oklahoma Medicaid Request for Proposals for Medicaid Non-Emergency Transportation (NET) services.

If the recipient is unable to travel independently it is the responsibility of the recipient to provide an escort. For the institutionalized recipients that utilizes the non-emergency waiver program service it is mandatory to have an attendant.

Access for the hearing and speech impaired may be satisfied by the use of appropriate telecommunication equipment.

EDUCATION MATERIALS

Medicaid recipients, with the exception of excluded populations, are automatically eligible for non-emergency transportation services. In the initial start-up of the program post cards were sent out to recipients, public meetings were held at local Department of Human Service offices, and advertisement in the local papers to inform them of the name and toll free telephone number for the Broker.

The local Department of Human Service county office workers explain the NET services and scheduling to recipients as they become eligible for Medicaid services or when the recipient asks the worker for information regarding transportation services.

The Broker is required to educate Medicaid recipients regarding advance scheduling and all aspects of the NET services. The Broker must follow the guidelines for education as set forth in the Title XIX Oklahoma Medicaid Request for Proposal for Non-Emergency Transportation Services. The education process may include information to first time callers, public meetings and distribution of written materials.

Selection and Availability of Providers

Selection Criteria

Provider Qualifications

The Broker must meet all Broker qualifications and standards outlined in the Title XIX, Oklahoma Medicaid Request for Proposal for Non-Emergency Transportation Services.

Broker's Background and Experience

The Broker must provide complete information regarding his/her financial responsibility and capabilities, proposed project organization and staffing, and experience. References must be provided to substantiate the Broker's qualifications and capabilities to perform the services required by the RFP.

Central Business Office

The Broker must establish a non-residential business office within the contract region. The broker may establish more than one business office within the region, but one non-residential office must be designated as the central business office.

All documentation must reflect the address of the location identified as the legal, dully licensed central business office. The business office must be open between the hours of 8:00 a.m. and 6:00 p.m., Central Standard Time, Monday through Saturday, except on State Holidays.

The central business office must have computer equipment and related software and telephone equipment to support call intake, eligibility verification and the ability to meet the required reporting requirements of the Oklahoma Health Care Authority. The office must be able to send and receive facsimiles and make copies of documents during regular business hours.

The Broker must have a project director in the central office and OHCA must have a direct administrative telephone number for the project director.

The Broker shall meet with OHCA representatives at OHCA offices in Oklahoma City on a periodic basis to discuss the NET program for the region and to answer pertinent inquires regarding the program, its implementation and its operation. ("Periodic" is defined as whenever OHCA or the Broker have pertinent items to discuss and need to meet face to face).

Selection Criteria (continued)

Insurance Requirement

Insurance will be at the expense of the Broker and be through a company licensed to do business in the State of Oklahoma. The Broker must maintain insurance which shall defend, indemnify and hold harmless the Broker and the State of Oklahoma from any claims which may result from the contract between the regional Broker and the State of Oklahoma, Oklahoma Health Care Authority from any claim for bodily injury, property damage or personal injury due to the operation of the contract. The Broker must provide the State a certificate of insurance that documents the amount of the liability carried.

License, Permit and Certification Requirements

The Broker must conform with Federal Laws which affect the delivery of services, under the contract, including but not limited to Title VI and VII of the Civil Rights Act and Title XIX of the Social Security Act, the Federal Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and 1993. OHCA will give the Broker the authority to implement federal regulations, as they become applicable, through a contract amendment. The Broker must ensure that all transportation providers, whether owned or sub-contracted, maintain licenses, permits or certifications for vehicles and drivers by all levels of Oklahoma government.

Vehicle Requirements

The Broker must assure that all transportation providers maintain all vehicles and vehicle equipment adequately to meet the requirements of the RFP. Vehicles and all components must comply with or exceed the manufacturer's state and federal, safety and mechanical operating and maintenance standards for the particular vehicles and models used under the contract. Vehicles must comply with applicable federal laws including the Americans with disabilities Act (ADA) regulations. Any vehicle found non-compliant with Oklahoma Licensing requirements, safety standards, ADA regulations, RFP requirements, or any other State or Federal law or regulation, must be removed from service immediately. All vehicles must meet basic requirements, such as heat, air conditioning, communication device and seat belts, safety seats, as appropriate.

GRIEVANCE PROCESS

A toll-free SoonerRide Call Center for non-emergency transportation services will be available to assist recipients with questions, comments, complaints and suggestions about Medicaid's non-emergency transportation program. Recipients should call the broker 72 hours prior to their doctor's appointment.

The Broker is responsible for responding promptly to complaints and notifying recipients of their right to appeal when services are denied or terminated. With the notification of their right to appeal, the Broker will include instructions on how and where to appeal the denial.

The Broker is required to maintain a written log of complaints that specify the complaint and the complaint resolution for a period of six (6) years.

A notice regarding denial or termination of services must:

- Be Sent to the recipient, in writing, within five(5) working days of the denial or termination of services;
- Include the specific reason for the denial or termination of service;
- Include an explanation of the recipient's right to appeal and that it may lead to a Fair Hearing. This is consistent with the Appeal and Fair Hearing process for Medicaid services which are provided via the fee-for-service payment system;
- The denial must be handed or mailed to the recipient and a copy retained in the Broker's files; AND
- Comply with ADA format requirements and be available in the languages required for that region.

The Broker must respond verbally to the complainant within 24 hours of the complaint.

The Broker must provide the Oklahoma Health Care Authority with a written record of the complaint, which included corrective actions taken and resolution of the complaint within five(5) working days of the receipt of the complaint by the Broker.

The Broker will have a liaison between the Broker and Oklahoma Health Care Authority and they will meet as needed.

FORMAL APPEAL PROCESS

If a Medicaid recipient is denied a service, the denial includes instructions to the recipient that he/she has the right to request a Fair Hearing by contacting the Oklahoma Health Care Authority. The request must be in writing and be received within twenty (20) days of the denial. The recipient is provided the contact address and information regarding the right to have counsel.

The SoonerRide Call Center's staff is trained to provide, upon request, the information necessary for a recipient with an unresolved complaint to access the formal appeals process through the OHCA Administrative Law Judge.

MONITORING ACCESS

a. Time and distance:

- Arrival on time for scheduled pick-up shall be standard practice. The broker is not required to wait more than fifteen (15) minutes after the scheduled pick up time.

- Medicaid recipients will be timely transported to and from scheduled appointments. Medicaid recipients will be advised of the pick-up time for transportation to appointments after the transportation request has been assigned to the transportation provider that will transport client.

- In multiple-passenger situations, no Medicaid recipient will remain in the vehicle more than one hour longer than the average travel time for direct transport from point of pick-up to destination.

- Late arrival or delivery must be reported to the dispatcher/transportation provider for the purpose of documenting the reason and appropriate follow-up. Trips will be monitored to ensure recipients are picked up and delivered timely to and from appointments.

- If a delay of fifteen minutes or more occurs in the course of picking up scheduled riders, the dispatcher/provider must contact proposed riders at their pick up points to inform them of the delay in arrival of vehicle and related and related schedule. The transportation provider must advise scheduled riders of alternate pick up arrangements when appropriate.

- Transportation outside the area customarily used for health care services by the recipient's immediate community is to be provided only when sufficient medical resources are not available in the area, or a health care provider has referred the recipient to health care services outside of the immediate community.

Appendix IV. C.1 continued

MONITORING ACCESS CONTINUED

b. Waiting time to obtain services:

The Medicaid eligible recipient is required to schedule an appointment for medically necessary, non-emergency transportation needs 72 hours in advance. It is the responsibility of the Broker to make every effort to arrange for non-emergency transportation services with less than 72 hours notice and in instances when transportation is needed for urgent care services.

The recipient will be provided training by the local Department of Human Services Office and by the Broker on how to schedule transportation services, instead of expecting transportation on demand.

c. Provider-to-beneficiary ratios:

The Broker is required to own or have service agreements with a sufficient number of non-emergency transportation providers to provide access to transportation that meets the service criteria for all residents in the NET region. This requirement includes access to special need transportation. The ratio of provider to recipients appears skewed since Oklahoma Medicaid will only deal with one Broker for statewide services for non-emergency transportation for all eligible Medicaid recipients.

Oklahoma Health Care Authority will monitor reports produced from the Broker's tracking software relating to the recipient's access to transportation services to ensure eligible recipients are being supplied the necessary transportation to medically necessary Medicaid services.

d. Beneficiary knowledge of how to appropriately access waiver services:

Oklahoma Medicaid recipients who are eligible to participate in the transportation waiver program are notified through the following means:

The recipient is told and given a brochure by the Department of Human Services caseworker about the non-emergency program at the time they apply and subsequently are certified in the Medicaid qualifying program. The brochure gives the recipient the process to access services, and a toll-free telephone number to use if he/she wants to request Non-Emergency Transportation (NET) services or has questions regarding the NET waiver services.

e. Access to emergency services:

Recipients will not receive emergency transportation services through the Broker.

Appendix IV.D

MONITORING QUALITY OF SERVICES

Complaints, grievance and appeals system

The Oklahoma Health Care Authority will continually monitor the Broker weekly, monthly and quarterly to assure that the level of service provided to Medicaid recipients is maintained and improved.

The Broker is responsible for responding promptly to complaints and notifying recipients of their right to appeal when services are denied or terminated. With the notification of their right to appeal, the Broker will include instructions on how and where to appeal the denial.

The Broker is required to maintain a written log of complaints that specify the complaint and the complaint resolution for a period of six (6) years.

A notice regarding denial or termination of services must:

- Be Sent to the recipient, in writing, within five(5) working days of the denial or termination of services;
- Include the specific reason for the denial or termination of service;
- Include an explanation of the recipient's right to appeal and that it may lead to a Fair Hearing. This is consistent with the Appeal and Fair Hearing process for Medicaid services, which are provided, via the fee-for-service payment system;
- The denial must be handed or mailed to the recipient and a copy retained in the Broker's files; AND
- Comply with ADA format requirements and be available in the languages required for that region.

The Broker must respond verbally to the complainant within 24 hours of the complaint.

The Broker must provide the Oklahoma Health Care Authority with a written record of the complaint, which include corrective actions taken and resolution of the complaint within five (5) working days of the receipt of the complaint by the Broker.

The Broker will have a liaison between the Broker and Oklahoma Health Care Authority and they will meet as needed.

OTHER QUALITY MONITORING

Quality of Services

The Oklahoma Health Care Authority (OHCA) shall monitor the Broker's performance under this contract through telephone contact and other means. OHCA reserves the right to audit the Broker's records to validate service delivery reports and other information.

OHCA staff or their agent may ride on trips to monitor service. The transportation provider's vehicles must be made available to OHCA or its agent(s) for inspection at any time.

OHCA staff or their agent reviews reports of complaints from recipients regarding service and response time for scheduling transportation.

OHCA expects the Broker's project manager or a designee must be available to respond to OHCA concerning these complaints immediately.

OHCA collect data on the Broker's and the transportation provider's performance and makes it available to interested parties in the form of a quarterly "report card". This data will include, but is not limited to:

a. Number of trips provided;
b. Number of requests for transportation denied, by reason;
c. Average daily phone calls received;
d. Percentage of pick-ups and deliveries completed on time; and
e. Number of complaints, by type.

OTHER QUALITY MONITORING

Periodic reviews

The Broker is required to retain specific data in their files regarding each trip made by a Medicaid recipient including the call, actual transportation service provider, vehicle and driver information, recipient name and Medicaid identification number, scheduled and actual pick-up, delivery and return times; special needs or escort service requirements, and date of services and destination.

The Oklahoma Medicaid Program has an Audit Unit as part of the Oklahoma Health Care Authority. It is the responsibility of this Unit to perform annual audits of Medicaid providers. This audit begins with a desk audit of six (6) months of Medical encounter data for compliance. A determination is then made whether to make an on-site visit.

The Oklahoma Health Care Authority (OHCA) will complete a periodic comparison of recipient access to transportation services before and after the waiver. The Broker will be reviewed to assure he maintains an adequate number of transportation service providers to provide transportation to all recipients residing in his region, and that the level of access remains consistent throughout the waiver period.

STATE INTERVENTION

The Oklahoma Health Care Authority (OHCA) or its designee will intervene when a Broker fails to perform according to the requirements and standards set forth in the Title XIX Oklahoma Medicaid Request for Proposal for Non-emergency Transportation Services.

OHCA will not intervene in problems between Brokers and transportation service providers.

OHCA may identify a condition of non-compliance and will notify the Broker and give the Broker the opportunity to become compliant.

OHCA will not be liable for more funding than the funding sources committed to the contract.

Rationale for Expected Cost Savings

A. General: In order to demonstrate cost effectiveness, the estimated costs without the waiver were developed using State Fiscal Year (SFY) 2002 as the base year. Costs were updated using an annualized trend factor of 14 percent, based on three years of actual fee-for-service (FFS) data from the period SFY97 to SFY99. This total trend factor assumes 3 percent inflation and an 11 percent utilization rate. This cost was then compared to the cost of delivering services without the waiver. The documentation for this comparison is presented in Exhibit 2. The State projected that enrollment will increase 4.5 percent from the base year to Year One of the waiver and is expected to remain relatively stable in Year Two.

B. Costs Without the Waiver - The State projected what the costs would be without the waiver by first evaluating costs prior to the waiver period. SFY02 was used as the base year. Adjustments were made to base year expenditures to account for incurred but not reported (IBNR), program changes, and trend (inflation and utilization).

1. **IBNR Adjustment –** Oklahoma increased base year paid claims expenses by $301,921 (a factor of 3.9 percent). There is about a 6 months claim lag for FFS payment of transportation services provided to recipients not included on the roster for non-emergency transportation (NET) at the beginning of the month.

2. **Program Changes –** A factor of 2.2 percent (169,381) was used to adjust base year expenditures for payment of transportation subsistence (meals and lodging to and from medical care) which the NET broker is expected to provide during the waiver period and was previously provided on a FFS basis.

3. **Trend Rate** – The trend rate reflects the expected increase in cost from the base year and Year One and Year Two of the waiver. The total trend rate consists of the increase in cost (inflation) and utilization. The trend rate was calculated using actual historical FFS experience from the period SFY97 to SFY99, which was 14 percent. By comparison, the growth rate from a more recent period, SFY00 to SFY02, was 24 percent. The trend rates are presented in the tables below.

				Avg. Annual Growth Rate

	SFY97	SFY98		97-99
NET Expenditures	$ 3,223,277	$ 3,700,000	$ 4,209,722	14%

	SFY00	SFY01	SFY02	Avg. Annual Growth Rate 00-02
NET Expenditures	$ 5,092,598	$ 5,927,583	$ 7,822,440	24%

There are several reasons for this significant increase in cost from these two periods. From SFY97 to SFY99, Oklahoma reimbursed NET on a mileage basis. In 1999, Oklahoma initiated a pilot program in seven counties using a transportation broker model. [1] This program became fully operational in SFY00. From SFY00 to SFY01, utilization increased modestly, while from SFY01 to SFY02, utilization increased from an average of 103 trips/1000 to 122 trips/1000, or 18 percent. This growth was the result of heightened awareness of the program and added coverage of the institutionalized population. The increased cost was also reflective of increased payment demand by subcontractors due to the need to replace vehicles.

Data from SFY97 to SFY99 was selected as the trend factor because this was the period prior to the change in the payment methodology and change in the covered population.

a) **Inflation** -The cost portion of the trend factor was developed using the Federal Travel Regulation mileage allowance for privately owned vehicles. We looked at three years of historical data for these rates to arrive at an average annual growth rate of 3%. Past year's rates are as follows:

Effective September 8,1998.....	$0.33
Effective April 1, 1999.....	$0.31
Effective January 14, 2000.....	$0.33
Effective January 22, 2001.....	$0.35

b) **Utilization** - The utilization rate is calculated as the difference in the total trend rate and the inflation rate, which is 11 percent.

[1] This change was the result of a 1998 internal review of NET policies and procedures and due to concerns raised in a June 18, 1999 report by the HCFA Section 1115 Managed Care Review Team regarding transportation access.

SFY02 adjusted costs were trended forward from the midpoint of the base period to the midpoint of the waiver year.

C. Costs Under the Waiver - In order to ensure cost effectiveness, the State will strive for the greatest negotiable savings. SFY02 costs under the broker model were trended forward from the midpoint of the base year to the midpoint of the waiver year. Since the midpoint of the waiver year is 1 ½ years advanced in time from the midpoint of the base year, 1 ½ year's growth was applied to the base year expenditures using a trend factor of 8 percent annually. (5 percent utilization and 3 percent inflation) This factor was based on the latest contract negotiations with the current broker.

D. Member Months – The projected member months during the two-year waiver period are shown in Exhibit 3.

Appendix D

There are no differences in the standards that providers must meet regarding reimbursement, utilization and quality under the waiver from those in the state plan.